

State/Territory: District of Columbia

Citation 4.15 Inspection of Care in Intermediate Care Facilities for the Mentally Retarded, Facilities Providing Inpatient Psychiatric Services for Individuals Under 21, and Mental Hospitals

42 CFR Part 456 Subpart I, and §1902(a)(31) and 1903(g) of the Act

- The State has contracted with a Peer Review Organization (PRO) to perform inspection of care for:
 - ICFs/MR;
 - Inpatient psychiatric facilities for recipients under age 21; and
 - Mental Hospitals.

42 CFR Part 456 Subpart A and §1902(a)(30) of the Act

- All applicable requirements of 42 CFR Part 456, Subpart I, are met with respect to periodic inspections of care and services.
- Not applicable with respect to intermediate care facilities for the mentally retarded services; such services are not provided under this plan.
- Not applicable with respect to services for individuals age 65 or over in institutions for mental disease; such services are not provided under this plan.
- Not applicable with respect to inpatient psychiatric services for individuals under age 21; such services are not provided under this plan.

State: District of ColumbiaCitation
42 CFR 431.615(c)
AT-78-904.16 Relations with State Health and vocational
Rehabilitation Agencies and Title V
Grantees

The Medicaid agency has cooperative arrangements with State health and vocational rehabilitation agencies and with title V grantees, that meet the requirements of 42 CFR 431.615.

ATTACHMENT 4.16-A describes the cooperative arrangements with the health and vocational rehabilitation agencies.

Revision: HCFA-PM-95-3 (MB)
MAY 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: District of Columbia

Citation

42 CFR 433.36(c)
§1902(a)(18) and
1917(a) and (b) of
the Act

4.17 Liens and Adjustments or Recoveries

(a) Liens

— The State imposes liens against an individual's real property on account of medical assistance paid or to be paid.

The State complies with the requirements of section 1917(a) of the Act and regulations at 42 CFR 433.36(c)-(g) with respect to any lien imposed against the property of any individual prior to his or her death on account of medical assistance paid or to be paid on his or her behalf.

— The State imposes liens on real property on account of benefits incorrectly paid.

— The State imposes TEFRA liens 1917(a)(1)(B) on real property of an individual who is an inpatient of a nursing facility,† ICF/MR, or other medical institution, where the individual is required to contribute toward the cost of institutional care all but a minimal amount of income required for personal needs.

The procedures by the State for determining that an institutionalized individual cannot reasonably be expected to be discharged are specified in Attachment 4.17-A. (NOTE: If the State indicates in its State plan that it is imposing TEFRA liens, then the State is required to determine whether an institutionalized individual is permanently institutionalized and afford these individuals notice, hearing procedures, and due process requirements.)

X The State imposes liens on both real and personal property of an individual after the individual's death.

TN No. 06-01
Supersedes
TN No. 85-3

Approval Date FEB 06 2006 Effective Date 10-01-2005

Revision: HCFA-PM-95-3 (MB)
May 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Washington, D.C.

(b) Adjustments or Recoveries

The State complies with the requirements of section 1917(b) of the Act and regulations at 42 CFR 433.36 (h)-(i).

Adjustments or recoveries for Medicaid claims correctly paid are as follows:

- (1) For permanently institutionalized individuals, adjustments or recoveries are made from the individual's estate or upon sale of the property subject to a lien imposed because of medical assistance paid on behalf of the individual for services provided in a nursing facility, ICF/MR, or other medical institution.

_____ Adjustments or recoveries are made for all other medical assistance paid on behalf of the individual.

- (2) The State determines "permanent institutional status" of individuals under the age of 55 other than those with respect to whom it imposes liens on real property under §1917 (a) (1) (B) (even if it does not impose those liens).

- (3) For any individual who received medical assistance at age 55 or older, adjustments or recoveries of payments are made from the individual's estate for nursing facility services, home and community-based services, and related hospital and prescription drug services.

X In addition to adjustment or recovery of payments for services listed above, payments are adjusted or recovered for other services under the State Plan as listed below:

All services and health Premiums paid under the State Plan, for individuals age 55 and over, except for Medicare cost sharing identified at 4.17(b)(3) continued.

TN No.: 11-04
Supersedes
TN No.: 06-01

Approval Date: JUL 15 2011 Effective Date: APRIL 1, 2011

Revision: HCFA-PM-95-3 (MB)
May 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Washington, D.C.

4.17 (b) Adjustments or Recoveries

(3) (Continued)

Limitations on Estate Recovery - Medicare Cost Sharing:

(i) Medical assistance for Medicare cost sharing is protected from estate recovery for the following categories of dual eligibles: QMB, SLMB, QI, QDWI, QMB+, SLMB+. This protection extends to medical assistance for four Medicare cost sharing benefits: (Part A and B premiums, deductibles, coinsurance, co-payments) with dates of service on or after January 1, 2010. The date of service for deductibles, coinsurance, and co-payments is the date the request for payment is received by the State Medicaid Agency. The date of service for premiums is the date the State Medicaid Agency paid the premium.

(ii) In addition to being a qualified dual eligible the individual must also be age 55 or over. The above protection from estate recovery for Medicare cost sharing benefits (premiums, deductibles, coinsurance, co-payments) applies to approved mandatory (i.e., nursing facility, home and community-based services, and related prescription drugs and hospital services) as well as optional Medicaid services identified in the State plan, which are applicable to the categories of duals referenced above.

TN No.: 11-04
Supersedes
TN No.: 06-01

Approval Date: JUL 15 2011

Effective Date: APRIL 1, 2011

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MAY 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: District of Columbia

- (4) — The State disregards assets or resources for individuals who receive or are entitled to receive benefits under a long term care insurance policy as provided for in Attachment 2.6-A, Supplement 8b.
- X — The State adjusts or recovers from the individual's estate on account of all medical assistance paid for nursing facility and other long term care services provided on behalf of the individual. (States other than California, Connecticut, Indiana, Iowa, and New York which provide long term care insurance policy-based asset or resource disregard must select this entry. These five States may either check this entry or one of the following entries.)
- The State does not adjust or recover from the individual's estate on account of any medical assistance paid for nursing facility or other long term care services provided on behalf of the individual.
- The State adjusts or recovers from the assets or resources on account of medical assistance paid for nursing facility or other long term care services provided on behalf of the individual to the extent described below:

TN No. 06-01
Supersedes
TN No. NEW

FEB 06 2006

Approval Date _____

Effective Date 10-01-2005

Revision: HCFA-PM-95-3 (MB)
MAY 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: District of Columbia(c) Adjustments or Recoveries: Limitations

The State complies with the requirements of section 1917(b)(2) of the Act and regulations at 42 CFR 433.36(h)-(i).

- (1) Adjustment or recovery of medical assistance correctly paid will be made only after the death of the individual's surviving spouse, and only when the individual has no surviving child who is either under age 21, blind, or disabled.
- (2) With respect to liens on the home of any individual who the State determines is permanently institutionalized and who must as a condition of receiving services in the institution apply their income to the cost of care, the State will not seek adjustment or recovery of medical assistance correctly paid on behalf of the individual until such time as none of the following individuals are residing in the individual's home:
 - (a) a sibling of the individual (who was residing in the individual's home for at least one year immediately before the date that the individual was institutionalized), or
 - (b) a child of the individual (who was residing in the individual's home for at least two years immediately before the date that the individual was institutionalized) who establishes to the satisfaction of the State that the care the child provided permitted the individual to reside at home rather than become institutionalized.
- (3) No money payments under another program are reduced as a means of adjusting or recovering Medicaid claims incorrectly paid.

TN No. 06-01
Supersedes
TN No. NEW

Approval Date FEB 06 2006

Effective Date 10-01-2005

Revision: HCFA-PM-95-3 (MB)
MAY 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: District of Columbia(d) ATTACHMENT 4.17-A

- (1) Specifies the procedures for determining that an institutionalized individual cannot reasonably be expected to be discharged from the medical institution and return home. The description of the procedure meets the requirements of 42 CFR 433.36(d).
- (2) Specifies the criteria by which a son or a daughter can establish that he or she has been providing care, as specified under 42 CFR 433.36(f).
- (3) Defines the following terms:
 - estate (at a minimum, estate as defined under State probate law). Except for the grandfathered States listed in section 4.17(b)(3), if the State provides a disregard for assets or resources for any individual who received or is entitled to receive benefits under a long term care insurance policy, the definition of estate must include all real, personal property, and assets of an individual (including any property or assets in which the individual had any legal title or interest at the time of death to the extent of the interest and also including the assets conveyed through devices such as joint tenancy, life estate, living trust, or other arrangement),
 - individual's home,
 - equity interest in the home,
 - residing in the home for at least 1 or 2 years,
 - on a continuous basis,
 - discharge from the medical institution and return home, and
 - lawfully residing.

TN No. 06-01
Supersedes
TN No. NEW

Approval Date FEB 06 2006 Effective Date 10-01-2005

Revision: HCFA-PM-95-3 (MB)
MAY 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: District of Columbia

- (4) Describes the standards and procedures for waiving estate recovery when it would cause undue hardship.
- (5) Defines when adjustment or recovery is not cost-effective. Defines cost-effective and includes methodology or thresholds used to determine cost-effectiveness.
- (6) Describes collection procedures. Includes advance notice requirements, specifies the method for applying for a waiver, hearing and appeals procedures, and the time frames involved.

TN No. 06-01
Supersedes
TN No. NEW

Approval Date FEB 06 2005 Effective Date 10-01-2005

Revision: HCFA-AT-91-4 (BPD)
AUGUST 1991

OMB No.: 0938-

State/Territory: District of Columbia

Citation
42 CFR 447.51
through 447.58

4.18 Recipient Cost Sharing and Similar Charges

1916(a) and (b)
of the Act

(a) Unless a waiver under 42 CFR 431.55(g) applies, deductibles, coinsurance rates, and copayments do not exceed the maximum allowable charges under 42 CFR 447.54.

(b) Except as specified in items 4.18(b)(4), (5), and (6) below, with respect to individuals covered as categorically needy or as qualified Medicare beneficiaries (as defined in section 1905(p)(1) of the Act) under the plan:

(1) No enrollment fee, premium, or similar charge is imposed under the plan.

(2) No deductible, coinsurance, copayment, or similar charge is imposed under the plan for the following:

(i) Services to individuals under age 18, or under--

Age 19

Age 20

Age 21

Reasonable categories of individuals who are age 18 or older, but under age 21, to whom charges apply are listed below, if applicable.

(ii) Services to pregnant women related to the pregnancy or any other medical condition that may complicate the pregnancy.

TN No. 05-01
Supersedes
TN No. 91-9

Approval Date FEB 24 2005

Effective Date OCT 1 2004

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

OMB No.: 0938-

State/Territory: District of Columbia

Citation 4.18(b) (Continued)

42 CFR 447.51
through
447.58

- (iii) All services furnished to pregnant women.
 Not applicable. Charges apply for services to pregnant women unrelated to the pregnancy.
- (iv) Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution, if the individual is required, as a condition of receiving services in the institution to spend for medical care costs all but a minimal amount of his or her income required for personal needs.
- (v) Emergency services if the services meet the requirements in 42 CFR 447.53(b)(4).
- (vi) Family planning services and supplies furnished to individuals of childbearing age.
- (vii) Services furnished by a managed care organization, health insuring organization, prepaid inpatient health plan, or prepaid ambulatory health plan in which the individual is enrolled, unless they meet the requirements of 42 CFR 447.60.

42 CFR 438.108
42 CFR 447.60

- Managed care enrollees are charged deductibles, coinsurance rates, and copayments in an amount equal to the State Plan service cost-sharing.
- Managed care enrollees are not charged deductibles, coinsurance rates, and copayments.

1916 of the Act,
P.L. 99-272,
(Section 9505)

- (viii) Services furnished to an individual receiving hospice care, as defined in section 1905(o) of the Act.

TN No. 05-01
Supersedes
TN No. 91-9

Approval Date FEB 24 2005

Effective Date OCT 1 2004

State/Territory: District of ColumbiaCitation

4.18(b) (Continued)

42 CFR 447.51
through
447.58

(3) Unless a waiver under 42 CFR 431.55(g) applies, nominal deductible, coinsurance, copayment, or similar charges are imposed for services that are not excluded from such charges under item (b)(2) above.

___ Not applicable. No such charges are imposed.

(I) For any service, no more than one type of charge is imposed.

(ii) Charges apply to services furnished to the following age groups:

___ 18 or older

___ 19 or older

___ 20 or older

X 21 or older

___ Charges apply to services furnished to the following reasonable categories of individuals listed below who are 18 years of age or older but under age 21.

State/Territory: District of Columbia

Citation
42 CFR 447.51
through 447.58

4.18(b)(3) (Continued)

(iii) For the categorically needy and qualified Medicare beneficiaries, ATTACHMENT 4.18-A specifies the:

- (A) Service(s) for which a charge(s) is applied;
- (B) Nature of the charge imposed on each service;
- (C) Amount(s) of and basis for determining the charge(s);
- (D) Method used to collect the charge(s);
- (E) Basis for determining whether an individual is unable to pay the charge and the means by which such an individual is identified to providers;
- (F) Procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b); and
- (G) Cumulative maximum that applies to all deductible, coinsurance or copayment charges imposed on a specified time period.

X Not applicable. There is no maximum.

State/Territory: District of Columbia

<u>Citation</u>	
§1916(c) of the Act	4.18(b)(4) — A monthly premium is imposed on pregnant women and infants who are covered under section 1902(a)(10)(A)(ii)(IX) of the Act and whose income equals or exceeds 150 percent of the Federal poverty level applicable to a family of the size involved. The requirements of section 1916(c) of the Act are met.
§1902(a)(52) and 1925(b) of the Act	4.18(b)(5) — For families receiving extended benefits during a second 6-month period under section 1925 of the Act, a monthly premium is imposed in accordance with sections 1925(b)(4) and (5) of the Act.
§1916(d) of the Act	4.18(b)(6) — A monthly premium, set on a sliding scale, imposed on qualified disabled and working individuals who are covered under section 1902(a)(10)(E)(ii) of the Act and whose income exceeds 150 percent (but does not exceed 200 percent) of the Federal poverty level applicable to a family of the size involved. The requirements of section 1916(d) of the Act are met. <u>ATTACHMENT 4.18-E</u> specifies the method and standards the State uses for determining the premium.

State/Territory: District of Columbia

Citation 4.18(c) X Individuals are covered as medically needy under the plan.

42 CFR 447.51
through 447.58

(1) An enrollment fee, premium or similar charge is imposed. ATTACHMENT 4.18-B specifies the amount of and liability period for such charges subject to the maximum allowable charges in 42 CFR 447.52(b) and defines the State's policy regarding the effect on recipients of non-payment of the enrollment fee, premium, or similar charge.

42 CFR
447.51 through
447.58

(2) No deductible, coinsurance, copayment, or similar charge is imposed under the plan for the following:

(i) Services to individuals under age 18, or under--

 Age 19

 Age 20

 X Age 21

Reasonable categories of individuals who are age 18, but under age 21, to whom charges apply are listed below, if applicable.

State/Territory: District of Columbia

Citation

4.18 (c) (2) (Continued)

42 CFR 447.51
through
447.58

(ii) Services to pregnant women related to the pregnancy or any other medical condition that may complicate the pregnancy.

(iii) All services furnished to pregnant women.

X Not applicable. Charges apply for services to pregnant women unrelated to the pregnancy.

(iv) Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution, if the individual is required, as a condition of receiving services in the institution, to spend for medical care costs all but a minimal amount of his income required for personal needs.

(v) Emergency services if the services meet the requirements in 42 CFR 447.53(b)(4).

(vi) Family planning services and supplies furnished to individuals of childbearing age.

§1916 of the Act,
P.L. 99-272
(Section 9505)

(vii) Services furnished to an individual receiving hospice care, as defined in section 1905(o) of the Act.

42 CFR 447.51
through 447.58

(viii) Services provided by a health maintenance organization (HMO) to enrolled individuals.

X Not applicable. No such charges are imposed.

State/Territory: District of Columbia

Citation

4.18(c)(3) Unless a waiver under 42 CFR 431.55(g) applies, nominal deductible, coinsurance, copayment, or similar charges are imposed on services that are not excluded from such charges under item (b)(2) above.

Not applicable. No such charges are imposed.

(i) For any service, no more than one type of charge is imposed.

(ii) Charges apply to services furnished to the following age group:

18 or older

19 or older

20 or older

21 or older

Reasonable categories of individuals who are 18 years of age, but under 21, to whom charges apply are listed below, if applicable.

State/Territory: District of Columbia

Citation 4.18(c)(3) (Continued)

447.51 through
447.58

(iii) For the medically needy, and other optional groups, ATTACHMENT 4.18-C specifies the:

- (A) Service(s) for which charge(s) is applied;
- (B) Nature of the charge imposed on each service;
- (C) Amount(s) of and basis for determining the charge(s);
- (D) Method used to collect the charge(s);
- (E) Basis for determining whether an individual is unable to pay the charge(s) and the means by which such an individual is identified to providers;
- (F) Procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b); and
- (G) Cumulative maximum that applies to all deductible, coinsurance, or copayment charges imposed on a family during a specified time period.

Not applicable. There is no maximum.

TN No. 91-9
Supersedes 86-6 Approval Date Nov 30, 1993 Effective Date 10/31/91
TN No. _____

HCFA ID: 7982E

State/Territory: District of Columbia

Citation

4.19 Payment for Services

42 CFR 447.252
§1902(a)(13),
1923, and
1902(e)(7)
of the Act

(a) The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart C, and sections 1902(a)(13) and 1923 of the Act with respect to payment for inpatient hospital services.

ATTACHMENT 4.19-A describes the methods and standards used to determine rates for payment for inpatient hospital services.

Inappropriate level of care days are covered and are paid under the State plan at lower rates than other inpatient hospital services, reflecting the level of care actually received, in a manner consistent with section 1861(v)(1)(G) of the Act.

Inappropriate level of care days are not covered.

57a

State/Territory: District of Columbia

Citation

42 CFR 447,434
438, and 1902(a)(4),
1902(a)(6), and 1903
conditions.

Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part
447, Subpart A, and sections 1902(a)(4),1902(a)(6), and 1903
with respect to non-payment for provider-preventable

Health Care-Acquired Conditions

The State identifies the following Health Care-Acquired
Conditions for non-payment under Section 4.19(A)

X Hospital-Acquired Conditions as identified by
Medicare other than Deep Vein Thrombosis
(DVT)/Pulmonary Embolism (PE) following total knee
replacement or hip replacement surgery in pediatric
and obstetric patients.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-
Preventable Conditions for non-payment under
Section(s) 4.19 A _____

X Wrong surgical or other invasive procedure
performed on a patient; surgical or other invasive
procedure performed on the wrong body part; surgical
or other invasive procedure performed on the wrong
patient.

TN No. _____

Approval Date JUL 26 2012 Effective Date JUL 1 - 2012

Supersedes

TN No. NEW

State/Territory: District of Columbia

Citation

42 CFR 447.201
42 CFR 447.302
52 FR 28648
§1902(a)(13)(E),
1903(a)(1)
1903(n), 1920, and
1926 of the Act

4.19(b) In addition to the services specified in paragraphs 4.19(a), (d), (k), (l), and (m), the Medicaid agency meets the following requirements:

- (1) Section 1902(a)(13)(E) of the Act regarding payment for services furnished by Federally Qualified Health Centers (FQHCs) under section 1905(a)(2)(C) of the Act. The agency meets the requirements of section 6303 of the State Medicaid Manual (HCFA-Pub. 45-6) regarding payment for FQHC Services. ATTACHMENT 4.19-B describes the method of payment and how the agency determines the reasonable costs of the services (for example, cost-reports, cost or budget reviews, or sample surveys).
- (2) Sections 1902(a)(13)(E) and 1926 of the Act, and 42 CFR Part 447, Subpart D, with respect to payment for all other types of ambulatory services provided by rural health clinics under the plan.

ATTACHMENT 4.19-B describes the methods and standards used for the payment of each of these services except for inpatient hospital, nursing facility services and services in intermediate care facilities for the mentally retarded that are described in other attachments.

§1902(a)(10) and
1902(a)(30) of
the Act

SUPPLEMENT 1 to ATTACHMENT 4.19-B describes general methods and standards used for establishing payment for Medicare Part A and B deductible/coinsurance.

State: District of ColumbiaCitation42 CFR 447.40
AT-78-904.19(c) Payment is made to reserve a bed during
a recipient's temporary absence from an
inpatient facility. Yes. The State's policy is
described in ATTACHMENT 4.19-C. No.TN. No. MMB 77-9
Supersedes
TN No.Approval Date 3-16-78Effective Date 10-1-77

State/Territory: District of Columbia

Citation

4.19 (d)

42 CFR 447.252
47 CFR 47964
48 CFR 56046
42 CFR 447.280
47 CFR 31518
52 CFR 28141

- (1) The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart C, with respect to payments for skilled nursing and intermediate care facility services.

ATTACHMENT 4.19-D describes the methods and standards used to determine rates for payment for skilled nursing and intermediate Care facility services.

- (2) The Medicaid agency provides payment for routine skilled nursing facility services furnished by a swing-bed hospital.

___ At the average rate per patient day paid to SNFs for routine services furnished during the previous calendar year.

___ At a rate established by the State, which meets the requirements of 42 CFR Part 447, Subpart C, as applicable.

Not applicable. The agency does not provide payment for SNF services to a swing-bed hospital.

- (3) The Medicaid agency provides payment for routine intermediate care facility services furnished by a swing-bed hospital.

___ At the average rate per patient day paid to ICFs, other than ICFs for the mentally retarded, for routine services furnished during the previous calendar year.

___ At a rate established by the State, which meets the requirements of 42 CFR Part 447, Subpart C, as applicable.

Not applicable. The agency does not provide payment for ICF services to a swing-bed hospital.

- ___ (4) Section 4.19(d)(1) of this plan is not applicable with respect to intermediate care facility services; such services are not provided under this State plan.

State: District of ColumbiaCitation42 CFR 447.45(c)
AT-79-50

4.19(e) The Medicaid agency meets all requirements of 42 CFR 447.45 for timely payment of claims.

ATTACHMENT 4.19-E specifies, for each type of service, the definition of a claim for purposes of meeting these requirements.TN. No. 89-9
Supersedes
TN No. 79-8Approval Date 12-8-89Effective Date 10-1-89

State/Territory: District of Columbia

Citation

42 CFR 447.15
AT-78-90
AT-80-34
48 FR 5730

4.19(f) The Medicaid agency limits participation to providers who meet the requirements of 42 CFR 447.15.

No provider participating under this plan may deny services to any individual eligible under the plan on account of the individual's inability to pay a cost sharing amount imposed by the plan in accordance with 42 CFR 431.55(g) and 447.53. This service guarantee does not apply to an individual who is able to pay, nor does an individual's inability to pay eliminate his or her liability for the cost sharing change.

State: District of ColumbiaCitation42 CFR 447.201
42 CFR 447.202
AT-78-904.19(g) The Medicaid agency assures appropriate
audit of records when payment is based on
costs of services or on a fee plus
cost of materials.

State: District of ColumbiaCitation42 CFR 447.201
42 CFR 447.203
AT-78-90

4.19(h) The Medicaid agency meets the requirements of 42 CFR 447.203 for documentation and availability of payment rates.

State: District of Columbia

Citation

42 CFR 447.201
42 CFR 447.204
AT-78-90

4.19(i)

The Medicaid agency's payments are sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that those services are available to the general population.

State: District of Columbia

Citation

42 CFR
447.201
and 447.205

4.19(j) The Medicaid agency meets the requirements of 42 CFR 447.205 for public notice of any changes in Statewide method or standards for setting payment rates.

§1903(v) of the
Act

(k) The Medicaid agency meets the requirements of section 1903(v) of the Act with respect to payment for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law. Payment is made only for care and services that are necessary for the treatment of an emergency medical condition, as defined in section 1903(v) of the Act.

State/Territory: District of Columbia

Citation

§1903(i)(14) of the Act 4.19(1) The Medicaid agency meets the requirements of section 1903(i)(14) of the Act with respect to payment for physician services furnished to children under 21 and pregnant women. Payment for physician services furnished by a physician to a child or a pregnant woman is made only to physicians who meet one of the requirements listed under this section of the Act.

State/Territory: District of ColumbiaCitation4.19 (m) Medicaid Reimbursement for Administration of Vaccines
under the Pediatric Immunization Program§1928(c)(2)
administration
(C)(ii) of
the Act(i) A provider may impose a charge for the
of a qualified pediatric vaccine as stated in
section 1928(c)(2)(ii) of the Act. Within this
overall provision, Medicaid reimbursement to
providers will be administered as follows.

(ii) The State:

 The District does not reimburse for the
administration of the vaccine. Sets a payment rate at the level of the
regional maximum established by the DHHS
Secretary. Is a Universal Purchase State and sets a
payment rate at the level of the regional
maximum established in accordance with State
law. Sets a payment rate below the level of the
regional maximum established by the DHHS
Secretary. Is a Universal Purchase State and sets a
payment rate below the level of the regional
maximum established by the Universal Purchase
State.The State pays the following rate for the
administration of a vaccine:§1926 of
the Act(iii) Medicaid beneficiary access to immunizations is
assured through the following methodology: CPE provides notice of the availability of the
program. Recipients are notified via efforts of
CPE/CHCF. All providers must participate in the vaccine
program.